

Audit



Report

OFFICE OF THE INSPECTOR GENERAL

DIRECT HEALTH CARE PROVIDER PROGRAM

Report No. 94-122

June 7, 1994

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Department of Defense

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Acronyms

CHAMPUS
MTF
OASD(HA)

Civilian Health and Medical Program of the Uniformed Services
Military Treatment Facility
Office of the Assistant Secretary of Defense (Health Affairs)



**INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
400 ARMY NAVY DRIVE
ARLINGTON, VIRGINIA 22202-2884**

June 7, 1994

**MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE (HEALTH
AFFAIRS)**

**SUBJECT: Audit Report on the Direct Health Care Provider Program (Report
No. 94-122)**

We are providing this report for your information and use. It discusses policies and procedures for obtaining the services of direct health care providers. Comments on a draft of this report were considered in preparing this final report.

Comments from the Deputy Assistant Secretary of Defense (Health Services Operations) on a draft of this report conformed to the requirements of DoD Directive 7650.3 and there are no unresolved issues. Therefore, no additional comments are required.

The courtesies extended to the audit staff are appreciated. If you have any questions on this audit, please contact Mr. Michael Joseph, Audit Program Director, at (804) 766-9108 or Mr. James Beach, Audit Project Manager, at (804) 766-3292. The distribution of this report is listed in Appendix C. The audit team members are listed inside the back cover.

David K. Steensma

David K. Steensma
Deputy Assistant Inspector General
for Auditing

Office of the Inspector General, DoD

Report No. 94-122
(Project No. 3LF-0007)

June 7, 1994

DIRECT HEALTH CARE PROVIDER PROGRAM

EXECUTIVE SUMMARY

Introduction. United States Code, titles 5 and 10, provide authorization for agencies to supplement military staffing in military treatment facilities through various means, including personal and nonpersonal services contracts, civilian direct hire, Military-Civilian Health Services Partnership Program, and hiring of intermittent employees. United States Code, title 10, section 1091, authorized the Secretary of Defense to contract with persons for services (including personal) for the provision of direct health care services. Section 1091 also established a limitation on the amount of compensation that could be received by a person contracted under that section. For FY 1993, the Military Departments administered about 1,360 contracts for professional health care services at a cost of about \$296 million.

Objectives. The objectives of the audit were to determine whether stated requirements for civilian direct health care providers are justified, appropriate means are used to obtain health care providers services, and compensation rates paid to such providers are reasonable and within statutory limitations. We also evaluated the internal controls applicable to direct health care provider contracts.

Audit Results. The Military Departments adequately justified stated requirements for civilian direct health care providers.

The Military Departments did not realize maximum efficiencies by contracting with groups or corporations to obtain the services of direct health care providers and as a result, the cost of providing health care to DoD beneficiaries was increased unnecessarily (Finding).

Internal Controls. The Internal Management Control Program was implemented for the contracting for direct health care providers. The audit identified no material internal control weaknesses. See Part I for a description of internal controls reviewed.

Potential Benefits of Audit. Potential monetary benefits were not quantifiable due to the limited scope of review and the planned or agreed to changes already in progress.

Summary of Recommendations. We recommend that the Assistant Secretary of Defense (Health Affairs) issue overall guidance on the use, desirability, and cost-effectiveness of the various methods of obtaining direct health care providers; and revise DoD Instruction 6025.5, "Personal Services Contracting Authority for Direct Health Care Providers," to establish authorized pay limits based on rank rather than years of service since degree attainment, for direct health care providers obtained under personal service contracts.

Management Comments. The Deputy Assistant Secretary of Defense (Health Services Operations) concurred with the finding and recommendations. The Deputy Assistant Secretary stated that the Office of the Assistant Secretary of Defense (Health Affairs) had issued a draft revision to DoD Instruction 6025.5 for coordination within DoD. The draft revision to the instruction satisfies the intent of the recommendations; therefore, additional comments are not required. Part II discusses management comments; and Part IV contains the text of management comments. The draft revision to the instruction is not included in Part IV because DoD coordination was not completed.

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This report was prepared by the Logistics Support Directorate, Office of the Assistant Inspector General for Auditing, DoD.

Part I - Introduction

Introduction

Background

Nonpersonal Services Contracting. United States Code (U.S.C.), title 10, section 2304, authorizes agencies to contract for the nonpersonal services of health care personnel. Nonpersonal services contracts include contracts under which the personnel rendering the services are not subject, either by contract terms or by the manner of contract administration, to the supervision and control usually prevailing in relationships between the Government and its employees. Policies and procedures for obtaining health care services of physicians, dentists, and other health care providers were established by the Federal Acquisition Regulation, subpart 37.4, "Nonpersonal Health Care Services." In addition to nonpersonal services contracts, U.S.C., title 5, allows agencies to obtain health care personnel, other than military, through civilian direct hire if authorized manpower spaces are available. By the 1980s, hiring health care personnel as civil service employees had become extremely difficult due to the disparity between civil service pay rates and civilian pay rates.

Personal Services Contracting. In 1983, Congress provided statutory authority in U.S.C., title 10, section 1091, for the Secretary of Defense to contract with persons for services (including personal services) for the provision of direct health care services. Personal services contracts include contracts that by their express terms or as administered, make the contractor personnel appear, in effect, Government employees. Section 1091 also established a limitation on the amount of compensation that a person could receive when contracted under this section. The compensation limit was established at a rate prescribed by the Secretary of Defense, but not at a rate greater than the basic pay and allowances authorized by U.S.C., title 37, chapters 3 and 7, for an officer in pay grade 0-6 with 26 or more years of service. DoD Instruction 6025.5, "Personal Services Contracting Authority for Direct Health Care Providers," February 27, 1985, established policies, responsibilities, and procedures applicable to contracting for personal services of direct health care providers.

Personal Services Compensation. To increase the utility of personal services contracting for obtaining needed health care providers, Public Law 101-510, November 5, 1990, increased the compensation limitation for direct health care providers. The Public Law changed the compensation limitation to the rate of basic pay, special and incentive pays and bonuses, and allowances authorized by U.S.C., title 37, chapters 3, 5, and 7, for a commissioned officer with comparable professional qualifications. Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)) memorandum, "Personal Services Contracts," January 27, 1992, provided interim guidance on implementation of the increased compensation limits provided by the Public Law. The interim guidance established a table of authorized compensation rates based on rank and the number of years experience since degree attainment. OASD(HA) issued on February 11, 1993, a draft revision to DoD Instruction 6025.5 that incorporated the interim guidance. The Office of the Assistant Inspector General for Auditing concurred with the revision stating that the instruction should address contracting for health care providers under both personal and nonpersonal

services contracts, criteria for determining the proper type of contract to be used in various situations, and applicability of compensation limitations to nonpersonal services contracts. OASD(HA) noted the disagreement but stated that the subject of nonpersonal services contracts would be addressed in a separate instruction to be issued at a later date.

Objectives

The objectives of audit were to determine whether stated requirements for civilian direct health care providers are justified, appropriate means are used to obtain health care providers services, and compensation rates paid to such providers are reasonable and within statutory limitations. We also evaluated the internal controls applicable to direct health care provider contracts.

Scope and Methodology

This audit covered one Army, two Navy, and one Air Force military treatment facility (MTF) that had 54 active direct health care provider contracts, with a total FY 1993 value of about \$35 million. We compared FY 1993 authorized staffing levels with on-board staffing and the most recent workload data available to determine whether requirements for direct health care provider contracts were justified. We obtained source workload data from the medical clinics within the MTFs. The Military Departments adequately justified stated requirements for civilian direct health care providers.

We also reviewed procedures and controls over the solicitation and award of direct health care provider contracts to determine whether adequate consideration was given to the type of contract contemplated and whether sufficient competition was sought and obtained. Further, we reviewed FY 1993 options on contracts awarded between FY 1989 and FY 1993 to determine whether they were for personal or nonpersonal services and if statements of work and contract documents clearly indicated the type of contract. We compared contractual compensation rates with statutory limitations on personal services contracts and with local prevailing rates on nonpersonal services contracts to determine if they were reasonable and within statutory limits. We also reviewed policies, procedures, and internal controls over monitoring contractor performance. We did not rely on computer-processed workload data or statistical sampling procedures to conduct this audit.

Introduction

This program audit was made from June through November 1993. The audit was made in accordance with auditing standards issued by the Comptroller General of the United States as implemented by the Office of the Inspector General, DoD, and included such tests of internal controls as deemed necessary. Appendix B lists the organizations visited or contacted during this audit.

Internal Controls

We limited our review of internal controls to determining whether the Internal Management Control Program had been implemented concerning contracting for direct health care providers. We reviewed internal control procedures to ensure that contract requirements were justified and that the quality of services received from contract providers were monitored. The review of procedures related to the monitoring of the quality of services was limited to determining that procedures had been established and did not include an evaluation of the actual quality of services received. Our review did not disclose any material internal control weaknesses.

Prior Audits and Other Reviews

Army Audit Agency Report No. SO 90-1, "Contracting For Direct Health Care Providers," November 6, 1989, reported that compensation rates specified in contracts awarded for direct health care providers exceeded statutory limitations by \$15.7 million during FYs 1987 and 1988. It further reported that excessive payments for this program during FY 1989 could total as much as \$10.6 million. The Army disagreed with the conclusion and the savings, and as a result the Army Audit Agency recommended that the Army's legal counsel issue an opinion on whether the compensation limits were exceeded. The Army's legal counsel issued an opinion that the contracts in question were not for personal services and were not subject to the statutory limitations.

Army Audit Agency Report No. SW 88-17, "William Beaumont Army Medical Center, El Paso, Texas," June 14, 1988, reported that the center had excessive emergency room physicians, costing about \$282,000 annually, that were contracted for under the direct health care provider program. It further reported that requests for augmentation personnel:

- o exceeded the approved table of distribution and allowances for personnel ceilings,
- o contained incorrect justification data,
- o were not properly ranked in order of priority, and
- o were not reviewed in sufficient depth to detect incorrect data.

The Army Audit Agency recommended that the number of physicians in excess of personnel ceilings be reported and the contract reduced accordingly. The Center commander concurred, alleging that personnel ceiling allowances did not reflect correct requirements. In response, the Army Audit Agency stated that the requirements for emergency room physicians had been overstated by the Center commander.

Other Matters of Interest

For the four MTFs reviewed, procedures for monitoring contractor performance to ensure that they were compensated only for actual hours worked or procedures performed either had not been implemented or were not effective. The procedures were inadequate because of the following reasons.

- o Providers failed to use sign-in and sign-out sheets.
- o Providers were allowed to sign in and sign out simultaneously.
- o Actual hours worked were rounded up for compensation purposes.
- o Providers were compensated on the basis of scheduled work hours.
- o No audits or reviews were performed to validate the procedures performed.

The weaknesses resulted in a lack of assurance that contractors were compensated for hours worked only or for procedures actually performed. The monetary effect of the weaknesses was insufficient to justify a finding and recommendation in the report, but the deficiencies were brought to the attention of the MTF commanders for correction. MTF commanders instructed responsible personnel to establish and enforce necessary procedures to correct the identified problems.

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Part II - Finding and Recommendations

Obtaining Direct Health Care Providers

The Military Departments did not realize maximum economies by contracting with groups or corporations to obtain the services of direct health care providers. The condition occurred because no overall guidance existed covering the use, desirability, and cost-effectiveness of the various methods available for obtaining direct health care services. Additionally, limitations placed on compensation payable to providers under personal services contracts reduced the usefulness of such contracts in obtaining direct health care providers. As a result, the cost of providing health care to DoD beneficiaries increased unnecessarily.

Background

U.S.C., titles 5 and 10, authorize the Military Departments to obtain the services of direct health care providers through several different methods. The authorizations allow MTF commanders to supplement military personnel in areas that are understaffed or when in-house resources are insufficient to meet health care needs. Policies and procedures on the various individual methods through which health care services may be obtained are in Office of Personnel Management, DoD, and Military Department guidance, as well as the Federal Acquisition Regulation. Available methods include personal services contracts, nonpersonal services contracts, civilian direct hire, partnership agreements, blanket purchase orders, and intermittent employees.

Group or Corporation Contracts

The Military Departments did not realize maximum economies by contracting with groups or corporations to obtain the services of direct health care providers. Contracts entered into with groups or corporations, for the provision of personal or nonpersonal health care services, were the least cost-effective method because the total cost contained management fees or administrative costs and profits. Personal services contracts create an employee and employer relationship between the provider and the Government while nonpersonal services contracts stipulate the status of the provider as an independent contractor. While the group or corporation may be reimbursed for reasonable administrative expenses and profits, the compensation paid to personal service health care providers employed by the group or corporation may not exceed limitations established by the OASD(HA). Cost data obtained for 10 personal services and 2 nonpersonal services contracts, valued at about \$10.9 million, with groups or corporations at two MTFs, showed that the use of alternative methods to obtain needed health care services could have avoided contractor health care costs of about \$1.6 million (see Appendix A).

For example, a personal services contract for three radiation therapy technicians was awarded to a corporation at a cost of \$92,500 per technician. The cost included a salary of \$58,240, paid to the individual provider, and overhead, general and administrative cost, and profit of \$34,260. Overhead, general and administrative cost, and profit on that contract represented a mark-up of about 59 percent of direct salary cost and equated to 37 percent of total cost. If those technicians could have been obtained through personal services contracts with individual providers, at the salary paid by the corporation, health care costs would have been reduced by \$102,780 ($\$34,260 \times 3$).

Guidance on Methods of Obtaining Health Care Providers

MTF commanders did not have a comprehensive guidance document that covered all methods of obtaining direct health care providers, which would allow MTF commanders to make decisions more effectively on the method that would satisfy health care needs at the lowest possible cost. Consideration of the appropriate use, desirability, and cost-effectiveness of each alternative method required review of multiple documents or coordination with supporting personnel and contracting activities to ensure compliance with applicable personnel and contracting policies and procedures. Comprehensive guidance should include the five methods available for obtaining direct health care providers discussed below.

Contracting with Individual Providers. When contracting is determined to be the only viable means of providing health care services, MTFs should attempt to negotiate personal services contracts with individual providers under the authority of U.S.C., title 10, section 1091. Section 1091 provides a limitation on the amount of compensation that can be paid to the provider and makes no provision for payment of other overhead or administrative costs. Contracting with individual providers will eliminate added management and administrative costs and the profit incurred on contracts with groups or corporations, thereby reducing health care costs.

Civilian Direct Hire. The Government is normally required to obtain its civilian employees by direct hire, under the authority of U.S.C., title 5, section 3101. Personnel hired under section 3101 are reimbursed under Federal non-special general pay schedules, which would normally result in lower salary costs than those payable under personal or nonpersonal services contracts. When a staffing shortage exists and is expected to continue, MTFs may find it more economical to obtain needed health care providers through civilian direct hire. If the MTF lacks the authorized civilian spaces to hire the health care providers, the MTF commander can request an increase in authorized spaces or the authority to exceed the authorization.

Because of the disparity between civil service salaries and local prevailing rates, civilian hiring has not always proven to be viable, therefore, the OASD(HA) has requested authority to reimburse DoD civilian direct health care providers under the provisions of U.S.C., title 38, sections 7431 and 7451. Section 7431

Obtaining Direct Health Care Providers

authorizes special pay for physicians and dentists retained by the Veterans Health Administration. Section 7451 provides the Veterans Health Administration with the authority to offer pay and benefits that are competitive with non-Veterans Health Administration facilities, in the same labor-market area, to nurses and other health care personnel. OASD(HA) officials believe that the higher compensation rates under title 38 will give MTF commanders the ability to hire nurses and other health care providers whose services have generally been obtained through personal or nonpersonal service contracts with groups or corporations.

Military-Civilian Health Services Partnership Program. U.S.C., title 10, section 1096, provides authority for MTF commanders to negotiate partnership agreements with civilian providers for services at a discounted Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) rate. When an MTF possesses underutilized facilities and equipment, commanders may find that entering into partnership agreements is the most economical means of providing health care to its CHAMPUS beneficiary population. The two types of partnership agreements are internal and external. Through the internal agreements the civilian health care providers treat CHAMPUS beneficiaries in the MTF, at the discounted CHAMPUS rate, with no cost to the beneficiary. External agreements allow military doctors to treat both active duty and CHAMPUS patients at civilian facilities when necessary facilities or equipment are not available at the MTF. Use of partnership agreements may allow the MTF to obtain the services of physicians that otherwise could be obtained only through personal or nonpersonal services contracts.

Blanket Purchase Agreement. When MTFs have need for health care provider services on other than a full-time basis, the use of blanket purchase agreements may prove to be the most economical method of obtaining health care services. A blanket purchase agreement is a simplified method of filling anticipated repetitive needs for supplies or services by establishing "charge accounts" with qualified sources of supply. Blanket purchase agreements can be established with one or more individuals, groups, or corporations for the provision of health care provider services. Under such agreements, the MTF may obtain health care provider services, with as little as a 2-hour notice, by placing a call or an order with the specified provider. Moncrief Army Community Hospital, Fort Jackson, South Carolina, was effectively using blanket purchase agreements to obtain nurses and other health care providers required to handle unexpected increases in work load and temporary staffing shortages, due to leave, training, etc.

Intermittent or When Actually Employed Personnel. MTFs can maintain a pool of intermittent or when actually employed personnel. Intermittent or when actually employed personnel are the same as civil service direct hires except that they do not receive civil service benefits. They are prohibited from working more than 39 hours a week, and they can refuse work. The services of intermittent or when actually employed personnel can be obtained on short notice and on a short-term basis when an unexpected increase in work load or a staffing shortage arises. Moncrief Army Community Hospital was effectively utilizing when actually employed personnel to handle unexpected requirements for nurses.

Limitation on Personal Services Compensation

Because of the personal services salary limitation (about \$151,000) prescribed in U.S.C., title 10, section 1091, MTFs generally entered into nonpersonal services contracts with groups or corporations to obtain the services of physicians and dentists. Restrictive guidance in the draft revision of DoD Instruction 6025.5 established authorized compensation rates, based on rank and years of experience following degree attainment, and made the use of less costly personal services contracts with individual providers impractical. The draft revision established salary levels for less than 2 years experience, for 2 to 6 years experience, etc. According to contracting personnel, an MTF's needs can normally be satisfied by physicians with 2 years experience. As a result, solicitations for contracts would have to be issued with a not to exceed cost equivalent to the salary level for a military officer with from 2 to 6 years of experience. Such restrictions further reduced the usefulness of personal services contracts to obtain physicians and other highly paid health care providers. Legislation is pending that would raise the compensation level for personal services contract to \$200,000 a year. OASD(HA) officials believe that this increase would help negate the necessity of contracting with groups or corporations; and it would allow hospital commanders to obtain the services of most types of health care providers through personal service contracts with individual providers. For the increased compensation level to be fully effective, restrictions of compensation based on years of service since degree attainment must be removed.

Pending Initiatives

The OASD(HA) is aware of the additional costs incurred when contracting with a group or corporation for direct health care provider services. The feasibility of various initiatives that may lead to a reduction in the costs of obtaining the services of direct health care providers is being reviewed. Those initiatives are:

- o raising the personal services salary cap,
- o implementing authority to hire health care personnel under U.S.C., title 38,
- o revising DoD Instruction 6025.5 to remove the table of authorized compensation based on years of practice following degree attainment, and
- o removing the 2-year prohibition against awarding personal services contracts to providers who served on active duty during the 12-month period preceding contract award.

The OASD(HA) is considering issuance of a DoD directive that would prescribe policies and procedures covering all methods by which a MTF commander may obtain health care providers.

Recommendations for Corrective Action

We recommend that the Assistant Secretary of Defense (Health Affairs):

1. Issue a guidance document covering all available methods of obtaining direct health care provider services to:

a. Establish specific criteria on determining the use, desirability, and cost-effectiveness of each method.

b. Establish procedures to ensure that adequate efforts are made to obtain providers through civilian hire, personal service contracts with individual providers, or partnership agreements before entering into more costly service contracts with groups or corporations.

2. Revise DoD Instruction 6025.5 to establish authorized pay limits, based on rank, without regard to years of practice since degree attainment, for direct health care providers obtained under personal service contracts.

Management Comments

The Deputy Assistant Secretary of Defense (Health Services Operations) fully concurred with the finding and recommendations. The Deputy Assistant Secretary stated that the Office of the Assistant Secretary of Defense (Health Affairs) issued a draft revision to DoD Instruction 6025.5 that is being coordinated within the DoD. The revision addresses new policies, responsibilities, procedures, applicabilities, implementation, and effective date for personal and nonpersonal services contracting authority. The revised instruction is effective immediately upon completion of DoD coordination and signature by the Assistant Secretary.

Part III - Additional Information

Appendix A. Cost Data on Group or Corporation Contracts Reviewed

Type of Provider	Number of FTEs ¹	Individual Provider Salary	Contractor Costs	Total Contract Amount
Clinic Nurse	7.77 ²	\$ 47,466	\$ 61,714	\$ 430,525
Critical Care and Labor/Delivery Nurses	51.55 ³	57,595	428,940	3,397,962
Emergency Room Nurse	8.47 ²	58,094	67,282	559,338
Emergency Room Physician (NP) ⁴	3.42	132,392	29,887	162,279
MRI ⁵ Technician	1	49,920	24,960	74,880
MRI ⁵ Technician	1	52,000	29,640	81,640
OB/GYN ⁶ Nurse Practitioner	0.5	33,480	10,044	43,524
Operating Room Nurse	14.77 ⁷	57,595	122,268	968,915
Operating Room Technician	9.06 ⁷	37,190	75,409	412,350
Physician Assistant	1	54,524	12,492	67,016
Primary Care Physician (NP) ⁴	0.68	105,445	28,287	133,732
Radiation Therapy Technician	3	58,240	102,780	277,500
Radiation Therapy Technician	1	54,072	23,470	77,542
Surgical and Obstetric Nurses	62.77 ³	55,994	522,269	4,037,012
Ultrasonographer	2	45,760	54,080	145,600
Total			<u>\$1,593,522</u>	<u>\$10,869,815</u>

¹ Full Time Equivalents.

² Emergency room and clinical nurses were obtained under the same contract.

³ Critical care, labor/delivery, surgical, and obstetric nurses were obtained under the same contract.

⁴ Nonpersonal service contract.

⁵ Magnetic Resonance Imaging.

⁶ Obstetrics/Gynecology.

⁷ Operating room nurses and technician were obtained under the same contract.

Appendix B. Organizations Visited or Contacted

Office of the Secretary of Defense

Office of the Assistant Secretary of Defense (Health Affairs), Washington, DC

Department of the Army

Office of the Surgeon General of the Army, Washington, DC
Headquarters, Army Health Services Command, Fort Sam Houston, TX
Moncrief Army Community Hospital, Fort Jackson, SC

Department of the Navy

Bureau of Medicine and Surgery, Washington, DC
Naval Hospital, Portsmouth, VA
Naval Hospital, San Diego, CA

Department of the Air Force

Office of the Air Force Surgeon General, Contracting Support Activity, Brooks Air
Force Base, TX
1st Medical Group, Langley Air Force Base, VA

Appendix C. Report Distribution

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House Subcommittee on Legislation and National Security, Committee on
Government Operations

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Part IV - Management Comments

Deputy Assistant Secretary of Defense (Health Services Operations) Comments



HEALTH AFFAIRS

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON DC 20301-1200

MAY - 6 1994

MEMORANDUM FOR INSPECTOR GENERAL, DEPARTMENT OF DEFENSE

SUBJECT: Draft Report on the Audit of Direct Health Care Provider Program
(Project No. 3LF-0007)

This memorandum responds to your draft report of March 3, 1994, which requested comments on two recommended Assistant Secretary of Defense (Health Affairs) corrective actions.

Recommendation 1. "Establish a guidance document covering all available methods of obtaining direct health care provider services to:

- a. Establish specific criteria on determining the use, desirability, and cost-effectiveness of each method.
- b. Establish procedures to ensure that adequate efforts are made to obtain providers through civilian hire, personal service contracts with individual providers, or partnership agreements before entering into more costly service contracts with groups or corporations."

Comment: Concur.

Corrective action taken: OASD(HA) has issued a draft revision to DoDI 6025.5 (copy attached) that is presently in coordination within the Department. The revision addresses new policies, responsibilities, procedures, applicabilities, implementation, and effective date for personal and nonpersonal services contracting authority.

Estimated dates for completion: The DoDI is effective immediately upon completion of Departmental coordination and signature of the Assistant Secretary of Defense (Health Affairs). The Services will forward implementing documents to our office within 120 days.

Recommendation 2. "Revise DoD Instruction 6025.5 to establish authorized pay limits, based on rank, without regard to years of practice since degree attainment, for direct health care providers obtained under personal service contracts."

Comment: Concur.


Corrective action taken: Same as action taken under recommendation 1.

Deputy Assistant Secretary of Defense (Health Services Operations) Comments

2

Estimated dates for completion: Same as estimated dates of completion under recommendation 1.

Thank you for the opportunity to comment on the draft report.


Harold M. Koenig, RADM, MC, USN
Deputy Assistant Secretary of Defense
(Health Services Operations)

Attachment:
As stated

The draft revision to DoD Instruction 6025.5 is not included because Departmental coordination was not completed.

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